

International consensus statement on attention-deficit/hyperactivity disorder (ADHD) and disruptive behaviour disorders (DBDs): Clinical implications and treatment practice suggestions

Stan Kutcher^{a,*}, Michael Aman^b, Sarah J. Brooks^{a,1}, Jan Buitelaar^c, Emma van Daalen¹, Jörg Fegert^d, Robert L. Findling^e, Sandra Fisman^f, Laurence L. Greenhill^h, Michael Huss^g, Vivek Kusumakar^a, Daniel Pineⁱ, Eric Taylor^k, Sam Tyano^j

^a*Dalhousie University Department of Psychiatry, QE II Health Sciences Centre, Abbie J. Lane Building-Suite 9212, 5909 Veterans' Memorial Lane, Halifax, Nova Scotia, B3H 2E2, Canada*

^b*Nisonger Center, Ohio State University, OH, USA*

^c*University Medical Center Nijmegen, Nijmegen, The Netherlands*

^d*Clinic for Child and Adolescent Psychiatry and Psychotherapy, University of Ulm, Ulm, Germany*

^e*Case Western Reserve University, University Hospitals of Cleveland, Cleveland, OH, USA*

^f*Department of Psychiatry, University of Western Ontario, London ON, Canada*

^g*Clinic of Psychiatry, University Hospital Berlin, Berlin, Germany*

^h*New York State Psychiatric Unit, Columbia University, New York, USA*

ⁱ*The Ross Center for the Study of Anxiety and Related Disorders, Washington, DC, USA*

^j*Department of Psychiatry, Tel Aviv University, Tel Aviv, Israel*

^k*Institute of Psychiatry, Maudsley Hospital, London, UK*

¹*Department of Child and Adolescent Psychiatry, Utrecht University Hospital, Utrecht, The Netherlands*

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Abstract

Researchers and clinicians worldwide share concerns that many youngsters with attention-deficit/hyperactivity disorder (ADHD) and/or disruptive behaviour disorders (DBDs) do not receive appropriate treatment despite availability of effective therapies. At the request of Johnson and Johnson (sponsor), 11 international experts in child and adolescent psychiatry were selected by Professor Stan Kutcher (chair) to address these concerns. This paper describes the experts' consensus conclusions, including treatment practice suggestions for physicians involved in the early treatment of youngsters with ADHD (or hyperkinetic disorder, in countries preferring this classification) and/or DBDs internationally: suggested first-line treatment for ADHD without comorbidity is psychostimulant medication aided by psychosocial intervention. For ADHD with comorbid conduct disorder (CD), psychosocial intervention combined with pharmacotherapy is suggested. For primary CD, suggested first-line treatment is psychosocial intervention, with pharmacotherapy considered as an 'add-on' when aggression/impulsivity is marked and persistent. Pharmacotherapy requires careful titration; full-day coverage is the suggested goal. Regular long-term follow-up is recommended.

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1. Introduction to the disorders

Attention-deficit/hyperactivity disorder (ADHD) and disruptive behaviour disorders (DBDs) are classified somewhat differently internationally due to the use of two different classification systems—the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV; (American Psychiatric Association, 1994)) and the International Clas-

* Corresponding author. Tel.: +1-902-473-2470; fax: +1-902-494-7119.

E-mail addresses: stan.kutcher@dal.ca (S. Kutcher), sarahwills100@hotmail.com (S.J. Brooks).

¹ Contact for pre-publication editorial correspondence. Sarah Brooks, 9 Island Creek Private, Ottawa, ON, K1Z 1C5, Canada. Tel.: +1-613-729-4382.

sification of Diseases, 10th Edition (ICD10; (World Health Organisation, 1993)).

DSMIV ADHD is one of the most commonly diagnosed childhood psychiatric disorders, and is estimated to affect 3–5% of school age youngsters (Popper, 1988; Buitelaar, 2002); the term ‘youngsters’ will be used to refer collectively to children and adolescents. It is characterised by persistent impairments in attention (or concentration) and/or symptoms of hyperactivity and impulsivity. ADHD is a chronic condition, associated with poor outcome in terms of academic achievement, social problems and employment instability (Weiss et al., 1985; Mannuzza et al., 1993; Weiss and Hechtman, 1993). Diagnosis of ADHD is about three to four times more common in males than in females (Ross and Ross, 1982; Gaub and Carlson, 1997), although this gender imbalance may be inflated to some extent by referral biases (more boys are sent for clinical assessment of ADHD than girls), and the imbalance has also been found to be less pronounced in adolescence than in childhood (Offord et al., 1987; Cohen et al., 1993).

The DBDs of DSMIV comprise conduct disorder (CD), oppositional defiant disorder (ODD) and DBD-not otherwise specified. (In this paper, the term ‘DBDs’ will be used to refer collectively to CD and ODD). CD is typified by a variety of persistent antisocial behaviours including acts of aggression, destruction of property, deceitfulness, theft and violation of commonly adhered to rules. Consensus estimates suggest that 1–5% of youngsters meet its diagnostic criteria (Wolraich et al., 1996; Loeber et al., 2000). Most epidemiological studies have found that CD is more common among adolescents than pre-adolescents (Boyle et al., 1993) and more prevalent among boys than girls (McDermott, 1996). As with ADHD, the literature suggests that this gender imbalance may become less pronounced in older samples (McGee et al., 1990). Youngsters with CD are at high risk of entering the juvenile justice system, having persistent aggressive and antisocial behaviours, and developing substance abuse in adulthood (Rutter and Giller, 1998; Scott et al., 2001). ODD is characterised by a sustained pattern of argumentative, hostile, resentful, disobedient and/or defiant behaviours towards adult authority figures. It is estimated to affect 5–10% of youngsters. While not all cases of ODD progress to CD, this pathway is considered to be a common route to CD (Lahey and Loeber, 1994; Lahey et al., 1995; Loeber et al., 2000) and cases of ODD may warrant psychosocial intervention. (Psychopharmacologic treatment would not be appropriate for cases of ODD in the absence of comorbidity, unless severe aggression and/or destructive behaviour persisted despite attempts at psychosocial interventions of established efficacy).

The DBDs of ICD10 include hyperkinetic disorder and CD, with ODD being one form of CD. For the purposes of this paper, ICD10 CD and ODD can be considered equivalent to DSMIV CD and ODD, respectively. Likewise, hyperkinetic disorder is the counterpart to DSMIV ADHD, although the diagnostic criteria of hyperkinetic disorder are

stricter, requiring severe, persistent and pervasive impairment in psychological development due to high levels of inattentiveness, restlessness and impulsivity. (All three of these behaviors are required for the diagnosis). Prevalence rates of hyperkinetic disorder are, therefore, considerably lower (about 1.5% in school age youngsters) than those for ADHD (Taylor, 1994). In other respects, however, and particularly in terms of the treatment suggestions provided in this paper, what is said for ADHD can also be considered true for hyperkinetic disorder.

ADHD can be subtyped as: (a) primarily inattentive type; (b) primarily hyperactive/impulsive type; or (c) combined type (presence of inattention and hyperactivity/impulsivity). In contrast, ICD10 hyperkinetic disorder is only subtyped by whether or not CD is also present (see comorbidity section below). In both DSMIV and ICD10, CD is subtyped according to its onset time: child-onset or adolescent-onset. ODD does not have recognized subtypes per se.

Irrespective of diagnosis, some researchers have attempted to subtype aggression that can be seen in a variety of psychiatric conditions, including ADHD and DBDs. ‘Predatory’ aggression refers to planned, often covert or cunning acts of aggression, whereas ‘affective’ aggression refers to aggression that is highly visible and that appears to be impulsive, unplanned, uncontrolled and reactive to external circumstances. The distinction may be important because preliminary research suggests that patients exhibiting affective aggression are more likely to have lower IQs and to be prescribed neuroleptic medications or lithium than patients exhibiting predatory aggression, who are more likely to have a history drug abuse (Vitiello et al., 1990). It is also possible that particular forms of treatment may prove to be more effective at treating one form of aggression than another (Malone et al., 1998); for further discussion of this topic, see Weinshenker and Siegel (2002).

2. Rationale, goals and methods of the international consensus meeting

2.1. Rationale

Among researchers and clinicians around the world, there are concerns that youngsters with ADHD/DBDs are not receiving the appropriate treatment that they need. Considerable research data indicate a biological basis to these disorders (see below), and compelling evidence has demonstrated their association with poor long-term outcomes in untreated cases. Effective treatments are available, and yet many such youngsters do not receive adequate treatment. Reasons for this are multiple, but a significant hindrance is the lack of public and professional awareness and/or understanding of the nature of these disorders.

Much of the lay community tends to view persistent abnormal behaviour as evidence that a youngster is either ‘mad, sad or just plain bad’, with youngsters with ADHD,

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